Today's Date: ___/___/___

Patient Information:

Patients Legal Name:______________________ Preferred name:________________

Date of Birth: ___/___/___ Sex: M F Email Address:______________________

Address:____

Phone #:________________ (Cell/Home/Work) Secondary Phone: ________________

Occupation & Employer:_____________________Siblings/Children________________

If applicable, Patients School Name:____

Parent/Legal Guardian and/or Spouse Information:

Parents/Patients marital status: Married/ Divorced/ Single/ Widowed

Relationship to patient:______________ Name:___________________________________

Date of Birth:___/___/___ Email Address:_________________________________

Phone #:________________(Cell/Home/Work) Occupation:__________________

Address:____

Relationship to patient:______________ Name:___________________________________

Date of Birth:___/___/___ Email Address:_________________________________

Phone #:________________(Cell/Home/Work) Occupation:__________________

Address:____

Orthodontic Insurance:

Coverage: Y N Insurance Co. Name:__________________________________
Insurance Co. Phone #:_________________
Insurance Co. Address:____
Policy Holder's Employer:____________________Policy Holder Name:_________________
Policy Holder DOB:___/___/___ ID #:________________ SSN:__________________
Group #:____________________

Patients Name:____

Family Physician:____

Family Dentist:____________________ Last Cleaning: ________________

Who may we thank for referring you?_________________________________

Medical History:

Smoke or use of tobacco in any form? Y N
Has patient had any psychological counseling? Y N
Have metal rods, pins, or implants? Y N
Diagnosed or treated for any of the following? (please circle any that apply to patient)

Asthma	Neurological Disorder	ADD/ADHD	HIV/AIDS
Seizures	Autism/Aspergers	Diabetes	Hepatitis
Allergies	Currently Pregnant	High Blood Pressure	Anemia

*Please list any other allergies, medical behavioral conditions:
____

*List ALL medication or over the counter drugs:
____

Does this patient require antibiotic premedication for dental treatment? Y N
____

Have there been injuries to the face, mouth or teeth? Y N
Has this patient ever sucked their thumb/finger? Y N
Does patient breathe predominantly through their mouth? Y N
Does patient have any speech problems? Y N
Does patient experience clicking or discomfort in their jaw joints? Y N
Does the patient grind or clench their teeth? Y N
Does the patient want orthodontic treatment? Y N
Does patient have any congenital abnormalities? Y N
Has patient been informed of any MISSING/EXTRA permanent teeth? Y N
Last physical within 1 year? Y N
Patient's current health is: Good Fair Poor